CITY OF ALEXANDRIA, VIRGINIA

REASONABLE ACCOMMODATION REQUEST/REVIEW FORM

PART I- TO BE COMPLETED BY THE REQUESTER:

To: _____
(Department Head)

From: _____
(Name of person requesting accommodation)

Address: _____

Telephone: (____) _____

Email: _____

1. I am requesting accommodation because (circle one):

(A) (**IF YOU ARE A MEMBER OF THE PUBLIC**) The accommodation will allow me to participate in a City program or service or to access a City facility.
Program/Service/Facility name:
_____

(B) (**IF YOU ARE A JOB APPLICANT**) I am applying for employment, and the accommodation requested will allow me to participate in the recruitment or examination for:
(Position title):
_____

(C) (**IF YOU ARE A CITY EMPLOYEE**) The accommodation will allow me to continue working in my current position or a position that I desire, and for which I am otherwise qualified.

1. My current job title is:
_____

2. My specific functional limitation is:
_____

The accommodation I am requesting is described below.
Describe the type of accommodation (if it is a purchasable item, please provide the model, number, cost, and where it can be obtained).

_____
_____
_____

THE CITY OF ALEXANDRIA IS COMMITTED TO THE AMERICANS WITH DISABILITIES ACT, TO REQUEST THIS FORM IN AN ALTERNATIVE FORMAT EMAIL MIKE.HATFIELD@ALEXANDRIAVA.GOV OR CALL 703.519.3357, TTY 711

Prepared, reviewed, and revised by Personnel Services Administration Division 8/07

3. Describe how this accommodation will assist you. **Please attach additional sheets as necessary**

_____
_____
_____
_____
_____

EMPLOYEE/APPLICANT/RESIDENT CERTIFICATION

I certify that I have a disability or medical condition that requires reasonable accommodation, which will be met by acquiring the equipment or services or making facility modifications or work adjustments described above.

_____ _____

Signature: **Date**

PART II- TO BE COMPLETED BY REQUESTER:

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I, _____, HEREBY AUTHORIZE:

Health Care Provider Name_____

Address_____

Phone Number/TTY_____

To any licensed physician, other licensed practitioner, hospital, clinic, or other medically related facility, or United States Veteran Administration: I authorize you to release to the City of Alexandria, Virginia, the above-requested information to be used solely for the purpose of evaluating my request for reasonable accommodation. This authorization shall be valid for a period 180 days after the date of my signature or earlier if revoked by me in writing to the City of Alexandria, Virginia. I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request. I further acknowledge that I have been informed that if the medical information contained herein is not released, my reasonable accommodation may be denied.

_____ _____

Requester's Signature **Date**

CITY OF ALEXANDRIA, VIRGINIA

REASONABLE ACCOMMODATION REQUEST RESPONSE

PART III- TO BE COMPLETED BY CITY STAFF:

☐ APPROVED

☐ DENIED
REASONS:

_____
_____
_____
_____

_____
DEPARTMENT DIRECTOR OR DESIGNEE DATE

_____
PERSONNEL SERVICES DIRECTOR OR DESIGNEE DATE

APPROXIMATED COST OF ACCOMMODATION: $_____

AR-6-29 Excerpts

1. *If the request is approved, the Director or department representative will notify the requester and make the necessary implementation arrangements. If the request is denied, the requester may appeal to the City's ADA Compliance Panel ("the Compliance Panel") within thirty (30) calendar days (see Section VI).*

2. *The review process, concluding with the approval or denial shall be completed in fifteen (15) working days from the date of the request, unless the requester and the department agree to an extension of time.*

   If a department reviews and approves the request for accommodation, it shall provide the accommodation without undue delay.

VI. APPEAL PROCESS

Department decisions on reasonable accommodation may be appealed to the City's ADA Compliance Panel comprised of the Director of Personnel Services or his/her designee, the Affirmative Action Officer and the Disability Resources Coordinator. The appeal must be submitted within thirty (30) calendar days from the date of notification by the Department. The Compliance Panel shall issue its decision and inform all parties of its decision within forty-five (45) calendar days. The department will provide all information requested by the Panel to facilitate this appeal. The decision of the Panel is final.

THE CITY OF ALEXANDRIA IS COMMITTED TO THE AMERICANS WITH DISABILITIES ACT, TO REQUEST THIS FORM IN AN ALTERNATIVE FORMAT EMAIL MIKE.HATFIELD@ALEXANDRIAVA.GOV OR CALL 703.519.3357, TTY 711

Prepared, reviewed, and revised by Personnel Services Administration Division 8/07